Gonorrhea from Birth to Adolescence

ONE IN FIVE reported cases of gonorrhea occurs in a person under 20 years old. The number of cases of gonorrhea diagnosed in children correlates as well with the index of suspicion of the physician as it does with the social class of the patient. Gonorrhea in the newborn almost always reflects an infected mother and can be prevented by routine antepartum culture and treatment. Gonorrhea after the first month of life most commonly follows some type of sexual contact, innocent or abusive, in the home. Management of prepubertal gonorrhea must include a search for the source of infection, usually another member of the household.

Gonococcal ophthalmia neonatorum in this country usually represents a failure of silver nitrate prophylaxis, not an absence of prophylaxis. Any conjunctivitis with onset from 12 hours to seven days after birth should prompt a search for the gonococcus. Intravenous administration of aqueous crystalline penicillin G in a dose of 50,000 units per kg of body weight per day for seven days is effective and can save sight. Use of saline irrigations and topical antibiotics in addition to intravenous therapy is recommended. Gonococcal ophthalmia may occasionally be seen in older children.

Postneonatal but prepubertal infection is two to three times more common in girls than in boys. Disease may be manifest as an obvious purulent vaginitis or a minor discharge with labial swelling. Treatment with aqueous procaine penicillin G given in a dose of 100,000 units per kg of body weight intramuscularly and probenecid, 25 mg per kg of body weight given by mouth, is usually effective. Admission to hospital is rarely required. Prepubescent girls may be more difficult to cure than women; follow-up culture is essential. Oropharyngeal and rectal gonorrhea, both more difficult to eradicate than urogenital infection, have been reported in very young children.

Septicemia, arthritis, peritonitis and rarely pelvic inflammatory disease may complicate gonorrhea in children. The efficacy of therapeutic regimens for complicated gonococcal infection in childhood is unproven. The Center for Disease Control recommends 100,000 units of penicillin G per kg of body weight per day for seven days, either aqueous crystalline penicillin given intravenously or procaine penicillin given intramuscularly. Patients over 6 years of age who are allergic to penicillin can be treated with tetracycline, 25 mg per kg of body weight as an initial dose followed by 40 to 60 mg per kg of body weight per day in four doses for seven days.

It is important to recall that eradication of today's relatively resistant gonococci requires high blood levels of antibiotic. Benzathine penicillin (Bicillin®) has no place in the treatment of gonorrhea in any age group. It is important to note that despite recent improvements in culture media, laboratory diagnosis is not always possible. A strongly suggestive clinical picture or smear of pus is sufficient to initiate treatment, although bacterial isolation should always be attempted.

ELIZABETH BARRETT-CONNOR, MD

REFERENCES

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Valium® in the Treatment of Status Epilepticus in Childhood

THERE ARE NOT MANY true emergencies in medical practice, but status epilepticus is one of those emergencies. It is a continuum of recurring convulsive activity in which there is no recovery between the attacks, or recovery is incomplete. A variety of manifestations are recognized, including prolonged confusional states, petit mal status, prolonged focal or partial seizures, and generalized or grand mal status epilepticus. It is the generalized status epilepticus that is particularly life threatening and may end in death. Mortality rates as high as 23 percent have been recorded.

Status epilepticus, as with other convulsive phenomena, is a symptom of some pathophysiological state rather than itself a specific disease, and a careful, methodical search must be undertaken to determine the cause of that convulsive activity. The many and varied causes of convulsive disorders are well described elsewhere.

When a patient presents in status epilepticus, attention must be given immediately to several actions: providing an efficient and stable airway with adequate oxygen supply, protecting the patient from self injury and administering drugs to control the convulsive activity. Barbiturates of one type or another, paraldehyde and diphenylhydantoin (Dilantin®) have all been used to terminate status epilepticus, but diazepam (Val-